STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

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R000000	This visit was for State Residential Licensure Survey. This visit included Investigation of Complaint IN00135911. Complaint IN00135911- Substantiated. Deficiencies related to the allegations are cited at R185. Survey dates: October 15-17, 2013 Facility number: 010064 Provider number: 0100064 AIM number: N/A Survey team: Beth Walsh, RN Courtney, Mujic, RN (October 16, 17, 2013) Karina Gates, Generalist Tom Stauss, RN Census bed type: Residential: 55 Total: 55 Census payor type: Other: 55 Total: 55 Sample: 9 These deficiencies reflect state	R000000	The following is the Plan of Correction for Brookdale Place of Fall Creek in regard to the statement of deficiencies for the annual survey completed on 10/17/2013. This Plan of Correction is not to be construed as an admission of or agreement with the findings or conclusions in the statement of deficiencies or any related sanctions or fine. Rather it is submitted as a confirmation of our on going efforts to comply with statutory and regulatory compliance. In this document we have outlined specific actions in response to identified issues we have not provided a detailed response to each allegation or finding nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on October 23, 2013, by Janelyn Kulik, RN.			

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R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure electrical rooms which enclosed hazardous electrical panels were kept locked. This had the potential to affect 15 residents out of a total of 23 residents who resided on the 3rd floor dementia unit. Resident's; #41, #42, #45, #48, #50, #51, #53, #54, #55, #57, #39, #60, #63, #67, #68. Findings include: Observations of unlocked electrical rooms were made on the following dates and times; 10/15/2013 at 12:10	R000148	Immediate ActionWhen the staff was made aware of the unlocked doors, they were locked immediately, The maintenance techincian replaced the current locks with more secure ones limiting access to managers only. Identifying others with potential to be affectedSince all mobile residents could be affected by this situation the maintenance technician immediately checked all doors requiring locks on the unit. All were found to be locked securely. Systemic changesNew auto locking knobs were ordered. They arrived and were installed on 10/17/2013. To assure the situation does not recur, the unit manager or charge	10/17/2013

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	p.m., 10/16/2013 at 11:50 a.m., and 10/16/2013 at 1:40 p.m. A room labeled "Electrical", located in the 3rd floor dementia unit main dining room, nearest to room 114 was observed to be unlocked. Another room labeled "Electrical", located in the 3rd floor dementia unit main common room, nearest to room 303 was observed to be unlocked. Both electrical rooms had an electrical panel on the wall. Each electrical panel had a sticker which indicated, "Danger! Hazardous voltage will cause severe injury or death." During the observation on 10/15/2013 at 12:10 p.m., 3 residents were observed to be sitting in the 3rd floor dementia unit dining room and no staff members were present. An interview with LPN #1, on 10/16/2013 at 1:45 p.m., indicated the doors to the electrical rooms should be locked. An interview with the Maintenance Director, on 10/16/2013 at 1:55 p.m., indicated he doesn't know why the electrical room doors were unlocked, he is the only one who would ever need to be in there. It should be locked at all times. An interview with the Executive Director, on 10/16/2013 at 2:20 p.m.,		nurse will add checking all doors for secure locks to their daily rounds list. MonitoringThe maintenance technician will monitor weekly to assure all locks are compliant. He will report his findings monthly to the Quality Assurance Committee who will monitor until three months of full compliance are achieved.	

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	indicated there is no specific policy related to keeping the doors locked, it is just an expectation. A document identifying residents who lived on the 3rd floor dementia unit and were able to ambulate or self propel was provided by the Executive Director, on 10/16/2013 at 2:10 p.m., and indicated, "ambulatory or self propelled residents; #41, #42, #45, #48, #50, #51, #53, #54, #55, #57, #39, #60, #63, #67, #68".			

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R000185	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have			

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	clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. Based on observation, interview and record review, the facility failed to provide a method in which to summons a staff person. This affected 5 residents on the 3rd floor and had the potential to affect all 22 residents residing on the 3rd floor of the facility. (Residents #53, 68, 48, 41, and 50) Findings include: An environmental tour of the facility was conducted with the Maintenance Coordinator on 10/17/13 at 11:00 a.m. At this time, he indicated the facility's call system was provided by way of the telephones in the room. All a resident must do is take the telephone off the receiver and the staff member assigned to the resident's room carries a portable phone, known as a scout phone, that rings and displays the room number of the resident requesting assistance. During observation of Resident #53's room on the 3rd floor, the phone was taken off the hook to test the call system. No staff member responded.	R000185	Immediate ActionThe maintenance technician was able to determine that the scout phone being used to receive resident calls was not working properly. The phone was replaced and the staff was again able to recieve resident calls. Identifying Others With Potential to be AffectedTo assure all residents have a proper method for calling for assistance, the Maintenance staff conducted a room by room audit to determine if there were any further issues. Systemic changesA repair company will be contacted to perform a check of the entire call system to assure it is in proper working order and will make any needed repairs. The maintenance tachnician will conduct routine testing of the call system on each floor to assure the system continues to function propeerly. MonitoringThe maintenance technician will report any issues to the quality assurance committee who will monitor until the system is found without issues.	11/16/2013

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	One brief ring was heard from the phone on the wall in the servery area. Upon observation of the phone in the servery area, a green emergency light was lit, but the phone did not continue to ring or display the room number from which the ring originated. During observation of Resident #68's room on the 3rd floor, the bathroom pull cord was pulled to test the call system. No staff member responded. One brief ring was heard from the phone in the servery area. Upon observation of the phone in the servery area, a green emergency light was lit, but the phone did not continue to ring or display the room number from which the ring originated. During interview with the Maintenance Coordinator on 10/17/13 at 11:45 a.m., the Maintenance Coordinator stated, "There's obviously something wrong with the phones. (Name of company) is coming on Monday. I was told this morning that four phones did not work on this floor. We need a new call system." He further indicated he had no evidence to suggest that the call system was properly functioning anywhere on the 3rd floor. During interview with LPN #1 on			

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	10/17/13 at 11:45 a.m., she stated, "In the last month, we've had problems with almost every phone on this floor. We've gotten new batteries...I came back from vacation on Monday (3 days prior), and only 1 phone worked, and today it stopped working. I honestly don't know if the servery phone worked or not." She further indicated none of the scout phones on the 3rd floor were currently working. The Maintenance Director provided a copy of a note given to him the morning of 10/17/13 by LPN #2 with the locations of 3rd floor nonworking bathroom call lights. It indicated the bathroom call lights for Residents #48, 41, and 50 as well as the 3rd floor public bathroom were not working. This State tag relates to complaint IN00135911.			

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to follow physician's orders for 1 of 5 residents randomly observed during medication pass observations. (Resident #55) Findings include: During a random observation, on 10/16/13 at 12:03 p.m., LPN #1 administered furosemide (medication that treats swelling/blood pressure) 40 mg (milligram) to Resident #55. Review of the October 2013 Physician's Orders, for Resident #55, indicated an order for furosemide 40 mg to be given 2 times a day at 8 a.m. and 2 p.m. During an interview with the Health and Wellness Director (HWD), on 10/16/13 at 12:16 p.m., she indicated staff were expect to follow physician's orders. The HWD also indicated there was a window of 1 hour before	R000241	Paper IDR is requested - see additional documentation Immediate ActionResident # 55 lives on the memory care unit. Resident #55 has a history of medication refusals and on the date in question had agreed to take Lasix if it was given with lunch. Resident is alert and able to determine that Lasix caused increase in urination and finds it unpleasant to lose sleep if it causes urination late into the night. When re-approached with requests related to his medication, may become agitated. LPN#1 who administered the medication believed she was respecting the resident's right to take or refuse medications and when the issue was brought to her atention, notified the physician of the request and obtained an order to give the medication per resident preference. which was at 8 am and noon. The notification occurred after the medications was given, but the outcome was that the resident received the Lasix twice daily as ordered and the Med Administration Record	11/15/2013

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	and 1 hour after the scheduled medication time, that would be an acceptable time to administer the medication. A policy titled, "Medication Pass," received by the Administrator, on 10/16/13 at 2:20 p.m., indicated, "...4. There is a two (2) hour timeframe of one (1) hour before designated time of administration and one (1) hour after. For example, if a medication is timed in the Medication Administration Record (MAR) for 9:00 a.m., the medication may be given after 8:00 a.m. and before 10:00 a.m." The policy also indicated, "...26. Administer all medications the way the physician had it ordered." On 10/17/13 at 10:01 a.m., the Administrator indicated the facility was unable to locate another order for the above medication to be administered at a different time than what was listed on the October 2013 Physician's Orders. She also indicated the above medication was given at the wrong time and the facility had a new order written. Review of a Physician's Order, dated 10/17/13 (no time), received by the Administrator at 10:01 a.m., on 10/17/13, indicated, "Clarification [sic]		time was adjusted to reflect the new order going forward. This new order was presented to the surveyor on 10/17/13.Identifying others with the potential to be affectedOther residents who are reluctant to take their medications at the prescribed times and make special requests of nursing also have the potential to be affected. Nurse interviews were conducted by the Health and Wellness Director/ Nurse designee to determine if there are other residentw who request medications at times other than prescribed. In the event any are found, the physician will be contacted for permission to adjust the prescribed times or methods of administration. Such changes will be added to the Medication Administration Record and updated in the residents' Personal Service Plan. Systemic changesNurses will receive in-service education from the Health and Wellness Director/Nurse designee regarding how to handle special requests from residents related to medication administration so that it will be consistently handled in an acceptable manner and according to policy. If a resident refuses a medication at the prescribed time, the nurse will make one more attempt during the prescribed parameters (1 hour before or 1 hour after the medication is ordered) In the event a time change is required	

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	order: Lasix (furosemide) 40 mg (symbol for 1) PO (by mouth) bid (twice a day) (symbol for "at") 8 AM [sic] et 12 PM [sic]."		or is requested by the resident and or the request is not unreasonable, the nurse will notify the physician and obtain physician orders prior to administering the medication outside papamenters, even if it means the medication is refused, until the physician has confirmed the new order is approved. MonitoringHWD will utilize an audit tool to monitor residents noted to have special requests regarding medications as well as those residents who refuse medications. Personal Serivce Plans will be updated to reflect these issues and preferences. Physician will be notified. HWD will report monthly observations of findings to the QA committee and Executive Director. The committee will continue to reveiw until three months of full compliance are ahcieved and on-going as deemed necessary.	

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure facility dishwashers were maintained in safe operating condition for 2 of 3 facility dishwashers. Findings include: An observation of the first floor servery dishwasher was performed on 10/15/2013 at 1:20 p.m. During the observation, the dishwasher cycle was run twice by Dietary Aide #4. The temperature gauge on the dishwasher read less than 100 degrees Fahrenheit for both the wash and rinse cycles on each of the two dishwasher runs. During an interview with Dietary Aide #4, at 1:25 p.m. on 10/15/2013, she indicated the temperature gauge on the dishwashing machine in the first floor servery does not work properly. Dietary Aide #4 indicated chemical test strips were used to check temperature of the machines. A record review of the first floor	R000273	Immediate ActionNew dish machines were ordered and arrived in the community on 10/24/13. They are to be installed by 10/31/13Identifying others with the potential to be affectedSince all residents have the potential to be affected by this issue, the dishwashers were replaced in both serving areasSystemic changesThe dietary manager will provide in-service training with all dietary staff after the installation of the new dishwashers to assure everyone understands the requirements and proper use of the new machines. The dietary staff will be introduced to new monitoring forms for dishwasher performance checks. MonitoringThe Dietary Managteer or his designee will receive/review daily machine checks to assure all chemicals and temperatures in the dishwashers are within compliance of regulations. The Dietary Manager will review his findings with the Quality Assurance Committee until three months of complete compliance are achieved.	10/31/2013

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	servery dishwashing machine temperature log was performed on 10/16/2013 at 12:01 p.m. The temperature logs indicated the first floor servery temperatures from August 1, 2013 through October 15, 2013 were all at "110 degrees." These temperatures were indicated to be wash cycle temperatures. An interview with the Dietary Manager was performed on 10/16/2013 at 12:05 p.m. During the interview, he indicated the temperatures listed in the log book were "not acceptable according to Brookdale policy." The Dietary Manager indicated he thought the wash cycle temperature should be "140 degrees." The Dietary Manager indicated the 110 degree temperatures that were recorded in the log books by staff members were "probably too low." The Dietary Manager indicated the facility was ordering new high temperature dishwashers for all kitchen areas due to the problem. A copy of the (Name of Company) dishwasher specifications for the first and third floor dishwashers was received from the Dietary Manager on 10/16/2013 and 2:11 p.m. The specifications for temperatures indicated the first and third floor			

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	servery dishwashers should reach a minimum wash and sanitizing cycle temperature of 120 degrees. An observation of the third floor servery kitchen dishwasher cycle was performed on 10/17/2013 at 12:08 p.m. The temperature gauge on the dishwasher indicated the temperature of the wash cycle did not exceed 100 degrees Fahrenheit. An interview with Dietary Aide #5 on 10/17/2013 at 12:10 p.m. was performed. She indicated the temperature gauge on the third floor servery dishwasher had not worked for "awhile." She indicated the staff would use chemical test strips to take wash cycle temperatures. The third floor dishwasher temperature log book was received from Dietary Aide #4 at 12:12 p.m. on 10/17/2013. A record review of the third floor kitchen servery's dishwasher temperature log book was performed on 10/17/2013 at 12:13 p.m. During the review, the record indicated no temperatures were recorded for the entire month of September and October of 2013. An interview with Dietary Aide #4 was performed at 12:14 p.m. on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	10/17/2013. She indicated staff had not been recording temperatures of the third floor dishwasher as the temperature gauge "wasn't working right."			